



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name and Address**

ST DAVID'S S AUSTIN MED CTR  
6000 NORTHWEST PARKWAY STE 124  
SAN ANTONIO TX 78249

**Respondent Name**

Hartford Underwriters Insurance

**Carrier's Austin Representative Box**

Box Number 47

**MFDR Tracking Number**

M4-14-1700-01

**MFDR Date Received**

February 10, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "PER TWCC EFF:3/1/08 EXP REIM \$40,300.57 (DRG 494 REIM per cms inpt pricer @ \$28,182.22 x 143% TWCC MARK UP = \$40,300.57 ). PER EOB INSUR PD \$28,279.52. NO PT RESP. ACCT UNDER PD BY \$12,021.05"

**Amount in Dispute:** \$12,021.05

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Our investigation has found that reimbursement for the above date of service was processed in accordance with Rule 134.404 and thus, no additional reimbursement would be warranted."

**Response Submitted by:** The Hartford

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8 – 12, 2013	Inpatient Hospital Surgical Services	\$12,021.05	\$0.00

**FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
  - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
  - 189 – REIMBURSEMENT BASED ON RATION: PERCENTAGE OR FORMULA BY STATE GUIDELINES
  - 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.

### **Issues**

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

### **Findings**

1. 28 Texas Administrative Code §134.404(e) states that: “Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
  - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.”

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
  - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 143 percent; unless
    - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is 494, and that the services were provided at ST DAVIDS SAUS MED CTR. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$19,754.36. This amount multiplied by 143% results in a MAR of \$28,248.73.
4. The total allowable reimbursement for the services in dispute is \$28,248.73. This amount less the amount previously paid by the insurance carrier of \$28,279.52 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

### **Conclusion**

For the reasons stated above, the division finds that no additional reimbursement is due.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
March 17, 2014  
Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**